Joint City / County Health Scrutiny Committee

Tuesday, 10 June 2014 at 10:15

County Hall, **County Hall, West Bridgford, Nottingham, NG2 7QP**

AGENDA

1	To note the appointment by the County Council of Councillor Parry Tsimbiridis as Chairman and Counci	
2	To note the membership of the committee	
3	Minutes of the Last Meeting Held on 13 May 2014	3 - 12
4	Apologies for Absence	
5	Declarations of Interests by Members and Officers:- (see note below) (a) Disclosable Pecuniary Interests (b) Private Interests (pecuniary and non-pecuniary)	
6	Intoxicated Patients Final Report	13 - 16
7	Terms of Reference	17 - 24
8	Work Programme	25 - 28

Notes

(1) Members of the public wishing to inspect "Background Papers" referred to in the reports on the agenda or Schedule 12A of the Local Government Act should contact:-

Customer Services Centre 0300 500 80 80

(2) Persons making a declaration of interest should have regard to the Code of Conduct and the Council's Procedure Rules. Those declaring must indicate the nature of their interest and the reasons for the declaration.

Councillors or Officers requiring clarification on whether to make a declaration of interest are invited to contact Julie Brailsford (Tel. 0115 977 4694) or a colleague in Democratic Services prior to the meeting.

(3) Councillors are reminded that Committee and Sub-Committee papers, with the exception of those which contain Exempt or Confidential Information, may be recycled.

(4) A pre-meeting for Committee Members will be held at 9.45 am on the day of the meeting.

(5) This agenda and its associated reports are available to view online via an online calendar - http://www.nottinghamshire.gov.uk/dms/Meetings.aspx

NOTTINGHAM CITY COUNCIL

JOINT CITY AND COUNTY HEALTH SCRUTINY COMMITTEE

MINUTES of the meeting held at Ground Floor Committee Room - Loxley House, Station Street, Nottingham, NG2 3NG on 13 May 2014 from 10.17 - 12.40

✓	Councillor Ginny Klein (Chair)	
	Councillor Pauline Allan	
✓	Councillor Mohammad Aslam	(minutes 82 – 85)
✓	Councillor Richard Butler	
	Councillor Azad Choudhry	
	Councillor John Clarke	
✓	Councillor Kay Cutts	(substitute for Councillor Handley)
✓	Councillor John Doddy	(minutes 79 – 84)
✓	Councillor Kate Foale	(minutes 79 – 84)
	Councillor John Handley	
✓	Councillor Carole-Ann Jones	
✓	Councillor Thulani Molife	
	Councillor Eileen Morley	
✓	Councillor Brian Parbutt	
✓	Councillor Parry Tsimbiridis (Vice-Chair)	
✓	Councillor Jacky Williams	

✓ indicates present at meeting

Colleagues, partners and others in attendance:

Tracy Madge	-	Assistant Director Clinical Strategy, NHS England Area Team, Derbyshire and Nottinghamshire
Dr Ian Matthews	-	Deputy Medical Director, NHS England Area Team, Derbyshire and Nottinghamshire
Ceri Charles	-	Deputy Programme Director for Better for You
Mohamed Rahman	-	Assistant Head of Pharmacy
Donna Clarke	-	Healthwatch Nottingham and Nottinghamshire
Jane Garrard	-	Overview and Scrutiny Coordinator, Nottingham City Council
Martin Gately	-	Democratic Services Officer, Nottinghamshire County Council
Angelika Kaufhold	-	Overview and Scrutiny Coordinator, Nottingham City Council

79 APOLOGIES FOR ABSENCE

Councillor Pauline Allan – taken ill at the meeting

Councillor Azad Choudhry
Councillor John Handley

80 DECLARATIONS FOR INTEREST

None.

81 MINUTES

The minutes of the last meeting held on 11 March 2014 were confirmed and signed by the Chair.

82 OUTCOME OF SUBMISSION TO CHALLENGE FUND TO IMPROVE ACCESS TO PRIMARY CARE

The Committee considered a report of the Head of Democratic Services and a joint presentation by Tracy Madge, Assistant Director Clinical Strategy, NHS England Area Team, Derbyshire and Nottinghamshire and Dr Ian Matthews, Deputy Medical Director, NHS England Area Team, Derbyshire and Nottinghamshire, relating to the Outcome of submission to Challenge Fund to improve access to Primary Care. The key points from the presentation included:

(a) The context and reasons:
- Pressures include 50% increase in GP consultations;
- 35% increase in emergency care admissions;
- 65% increase in secondary care episodes for >75;

(b) There is a lot of evidence to support the following factors:
- Demographic changes;
- Poorly joined up services between primary, secondary and social care;
- Technical advances
- Economic pressures;
- Workforce pressures including increasing challenges in recruiting new GPs whose working day is becoming increasingly pressurised seeing on average 60 patients per day.

(c) The aim is to deliver high quality care and to achieve this through:
- Better access to primary care (GPs) for all, 7 days per week with extended hours (8am – 8pm);
- Patients with long-term/complex conditions being able to spend more time at their appointments with their GP;
- The introduction of personalised health plans for patient/carers;
- More joint education and training programmes for all staff;
- Appraisals and workforce plans for all staff;
- Improved and shared use of technology such as Skype or Facetime;
- Greater collaboration across providers, GPs, Pharmacy, Dental and Optometry as well as sharing good practice and ideas;
- Conducting independent checks and reviews of all providers for example the Fit to Practice revalidation of GPs;
- Services delivered in well equipped buildings;

- A payments system that rewards better patient outcomes.

(d) The Challenge Fund was launched by the Prime Minister:
- £50 million to help improve access and stimulate innovation by testing new ways of working;
- 250 expressions of interest were received in January 2014;
- 20 pilot projects across England were announced in April 2014 including the successful Derbyshire and Nottinghamshire "collaborative" bid for £5.2 million). This is a 12 month project consistent with the local 5 year strategy.

(e) This project aims to improve the quality of service for 1.2 million patients locally from 85 general practices across Derbyshire and 71 general practices from across Nottinghamshire, by:

- Increasing the number of appointments available by offering 7 day services Saturday and/or Sunday through locality hubs for up to 537,000 patients by March 2015;
- Implementing new ways of communication through email/Skype for 328,300 patients by March 2015;
- Increasing choice by enabling patients to access services from other GP sites;
- Introducing and roll out of telecare services so patients can help manage their own care;
- Providing joined up services between the GP and the hospital with GPs responding to avoid unnecessary increases in Accident and Emergency and hospital admissions.

(f) The implementation, monitoring and governance arrangements for the pilot include:
- The Area Team is supporting the implementation of the pilot and communication and reporting arrangements with patient involvement groups;
- The Clinical Commissioning Groups (CCGs) are strengthening their project management to ensure delivery of these plans at the general practice level;
- Independent monitoring and evaluation of the pilot and plans will take place;
- The Challenge Fund scenario model:
  - Includes the assumed benefits;
  - Assumes that the cost of the scheme against breaks even from reduction in acute provider costs;
  - Is free to the NHS and Social Care;
  - Can be expanded to include all other providers and metrics from the system plans;

(g) The wished for outcomes are:
- Patients will have personal health plans for improving outcomes;
- Workforce plans to meet needs;

- Finding different ways of working through transformation of services and delivery of services;
- Premises will be aligned to meet the needs of the population;
- Payments will be targeted to reward improved outcomes for patients which provide better value for money.

Following the presentation the following additional information was provided in response to questions:

(h) Part of the requirement for the pilot was to show how sustainable it is once funding from the Challenge Fund has ceased. This hopefully will be achieved by reducing the number of patients going to secondary care (hospitals and Accident and Emergency). This is part of the evaluation process for the pilot and a massive challenge, especially if the numbers attending secondary care do not reduce.

(i) Home visits should be available for frail/elderly patients or those with long-term chronic conditions who are unable to attend GP practices but the preference is for patients to go to medical centres as they are fully equipped and provide better facilities for doctors to access patient files and equipment etc.

(j) Funding the additional workforce needed to deliver the pilot is only available for one year and the bid had to show how this will be sustainable in the longer term. The level of funding is £5.2 million which in context of the annual budget for the NHS is very low.

(k) In relation to the preference for GP practices to open on Saturdays rather than Sundays, this was identified through consultation and generally it was more about convenience, for example for patients who work during the work it can be more difficult to get time off work. However, it would be impossible to require early to late or 7 day a week opening on all practices due to the funding implications but also the recruitment and retention of new GPs. The Out of Hours and urgent care services will still be available for people to access.

(l) Nottingham is already at the forefront of developing and using Apps (for mobile phones, tablets and laptop devices etc) to support patients to manage their own healthcare for long-term and chronic conditions such as diabetes etc and the feedback from patients has been very positive so far.

(m) The funding for the pilot has been split according to the size of CCGs and the populations they support. There is significant variation in the number of patients, and number of GP practices within the CCG area. For example, Nottingham City has a high number of small single handed practices whilst Derbyshire tends to have larger practices.

(n) The bid was developed as a result of individual CCGs suggesting what schemes might add value and would be willing to support in their area. This has resulted in variation in the pilot schemes being trialled across the area, but learning is being shared across the region. All the proposed schemes were tested against the criteria as part of the bidding process.

(o) It is essential that all the pilot activities are evaluated by the Team as a whole to identify what does and does not work, sustainability, and ultimately what will add value and improve access. Learning from successful pilots will be rolled out across the region.

(p) The workforce plan includes all practitioners involved with GP practices such as nurse practitioners and community matrons and existing good practice should be shared by all.

(q) It is hoped that through better education of patients it will become clearer to them whether they need to see a GP, nurse practitioner or pharmacist to deal with medical issues and this should improve access for those who do need to see a GP.

(r) The Challenge Fund is about improving access to primary care services and the project criteria is firmly focuses on this so whilst other professionals such as community matrons etc are not specifically involved their contribution to the overall work and sharing of good practice at a local level is very valued.

(s) There are 45 measures that the pilot will be evaluated against. The evaluation will be carried out by two researchers against the existing baselines, and will include looking at:

- Qualitative and quantitive research;
- Satisfaction surveys;
- Impact on Out of hours service;
- Impact on ambulance services;
- Focus groups with patients and staff surveys before and after the pilot to measure the impact;
- The number of A&E attendances.

This data can also be compared with statistics from GP practices which fall outside of the pilot.

A view was expressed that some of the proposals were difficult to implement due to GP capacity, for example extending patient appointments may increase the number of delayed appointments and reduce the number of patients that a GP can see in each day. It was also suggested that if practices were required to open longer hours, 7 days per week the number of doctors willing to become GPs may reduce as historically the more family-friendly hours have been an attraction of the job. The demand for GP appointments has risen substantially and there is a need to manage patient expectations and educate them more about when it is appropriate to visit a GP for minor ailments such as sore throats and headaches. There is a risk that by increasing the availability and access to GPs it could actually increase demand rather than meet existing requirements.

A representative from the local Royal College of Nursing (Maria Hannah) commended the paper 'Harnessing the Potential' to the Committee and speakers and offered to work in partnership locally on the pilots which was welcomed by Tracy Madge and Dr Ian Matthews.

RESOLVED to

(1) add to the work programme,

(a) progress on developing 24 hour services;

(b) the outcomes of the evaluation of Challenge Fund pilot projects in Nottinghamshire/Derbyshire;

(2) note the contents of the report and the presentation and thank Tracy Madge and Dr Ian Matthews for their contribution and information supplied at the meeting.

83 NOTTINGHAM UNIVERSITY HOSPITALS PHARMACY DELAY

The Committee considered a report of the Head of Democratic Services and joint presentation by Ceri Charles, Deputy Programme Director for Better for You and Mohamed Rahman, Assistant Head of Pharmacy relating to improving the pathway for patients leaving hospital and delays waiting for medicine from hospital pharmacies. The key points raised in the presentation included:

(a) The context is that during 2013/14 10% of Nottingham University Hospitals (NUH) complaints were discharge-related which was a reduction from 13% in 2012/13. The main reason cited for delays was 'waiting for tablets' but this captured a variety of different issues and reasons for delay. Previously there was no robust way of capturing and measuring waiting times and no single lead practitioner responsible for the discharge process which passed through a number of different staff at different times. A project was set up to review the systems and processes, culture and communication with patients and identify areas for improvement.

(b) The priority 'fewer waits' which includes delays for drugs and medicines is a quality priority for NUH in its Quality Account 2014/15.

(c) The NUH target for outpatient's pharmacy is a waiting time of less than 30 minutes. During April 2014 there were 5,704 outpatients seen at the pharmacy with 18,000 medications dispensed. The average wait during this period was 26 minutes and 99% of prescriptions were dispensed within 60 minutes by the Queens Medical Centre and 93% by the City Hospital pharmacies.

(d) There can be many reasons for wait in dispensing prescriptions including the pharmacist having to check that the drug dosage, frequency and duration are correct and that the instructions are clear. Occasionally the pharmacists have to check with the prescribing doctor because the instructions are unclear or there are questions about dosages and allergies etc. Errors and omissions by doctors identified by pharmacists affect approximately 5% of prescriptions.

(e) Some prescriptions may also not be 'off the shelf' and have to be made up by pharmacy which can also create further delays

(f) There are also unexpected periods of high demand for example clinics closing at the same time etc and issues such IT system failures which cause delays. The service has halved the average time delays for issues within its control since May 2012.

(g) The process for discharging or patients and providing their prescriptions was explained as follows:

- Patient is deemed medically stable and ready for discharge and informed they can go home
- The 'ToTakeOut' (TTO) prescription is written and checked by pharmacy and if no rework is needed then prepared
- The prescription is delivered to the ward and has to be signed off by the nurse which can create delays if the ward is very busy
- The patient is given the TTOs and leaves

(h) This process should take about 1 to 2 hours for 'simple' discharges but there have been reports of patients being told in the morning they are going to be discharged and then waiting up to 5 hours for the prescription before they can leave. There are many reasons that this could happen include having to check the accuracy of prescriptions and bespoke medication etc. One of the issues is that the doctor may tell the patient that they can be discharged but it is not until the end of the ward round (which may be another couple of hours) that s/he starts the process for discharging the patient. This means there can be a difference between when the patient views the discharge process as starting and when the process actually commences and can give a mis-leading impression to the patient about the expected time until discharge.

(i) Simple transfer and discharge can take place quickly and are usually when patients do not have complex needs (ie social care arrangements have to be in place prior to leaving hospital etc) or bespoke prescriptions which need making up. Supported Transfer refers to those with more complex needs which include co-ordinating with other services such as social services.

(j) As part of the review, a new E-prescribing system is being explored and procurement of this should take about two years.

(k) Another option is for pharmacists to accompany doctors on their ward rounds and if patients are informed that they are going to be discharged the prescription system starts at that point rather than waiting for the rounds to finish with doctors writing up prescriptions at that point.

During discussion the following additional information was provided in response to questions:

(l) Pharmacists accompanying doctors on ward rounds visits have not started yet. There will be a 20 ward pilot scheme and staffing resources are currently being sought to implement this proposal.

(m) The pharmacy tells outpatients how long they may have to wait for their prescription as soon as it is handed in and there are television monitors which

show the progress of each prescription and waiting times. The outpatient pharmacy waiting area at QMC is currently being refurbished and this will provide a more pleasant area to wait in.

(n) This project is still in its early stages (6 months) and the team receive feedback from patient groups as to discharge processes and waiting times, staff are also continually ward walking to identify issues which create delays and difficulties in the discharge process. It is a major project and improvements and changes in culture and systems will not happen overnight.

(o) It was suggested that a significant number of patients take their prescriptions to their GP surgery rather than waiting for it to be dispensed at the hospital pharmacy. NUH does not have any data on the number of prescriptions not taken to its pharmacy but would be interested in this information. It was suggested this issue needed to be explored.

(p) Views were expressed that although there was a lot of work going on to reduce delayed discharges and the impact that pharmacy waiting times had on this, there were issues with waiting times and delays in the outpatient pharmacy that also needed to be addressed.

In response to some of the issues raised Ceri Charles confirmed that the focus of the review to date had been primarily on in-patient discharge pathways, however given the clear concerns raised at this meeting about outpatients waiting times for prescriptions this issue would be taken back to the project team for exploration. Some of the issues should hopefully be resolved when the refurbished waiting area opens.

The Committee felt better informed about the discharge process and the impact that dispensing of prescriptions has on the process. There was a feeling that patients could be better informed about the process and the likely timescales so that expectations could be more realistic.

RESOLVED to

(1) note the evidence provided for the pharmacy waits review;

(2) gather data from GPs about the number of prescriptions from Nottingham University Hospitals Trust that they deal with.

84 QUALITY ACCOUNTS 2013/14

The Committee considered a report of the Head of Democratic Services outlining the process for the drafting and submission of comments for inclusion in the Quality Accounts 2013/14 for Nottingham University Hospitals NHS Trust, Nottinghamshire Healthcare Trust, Circle – Nottingham Treatment Centre and the East Midlands Ambulance NHS Trust.

Study groups were taking place to review the draft Quality Accounts from the key providers (except East Midlands Ambulance NHS Trust) and following these meetings comments will be drafted and will be emailed to all members of this Joint

Committee with the final approval for submission being delegated to the Chair or Vice-chair and in their absence the Chair of the relevant Study Group.

RESOLVED that delegated authority be given to the Chair or Vice-Chair of this Committee, or in their absence the Chair of the relent Study Group to approve comments to be submitted in to the following Quality Accounts 2013/14:

- **Nottinghamshire University Hospitals NHS Trust**
- **Nottinghamshire Healthcare NHS Trust**
- **Circle – Nottingham Treatment Centre**
- **East Midlands Ambulance Service NHS Trust**

85 WORK PROGRAMME

The Committee considered a report of the Head of Democratic Services including the provisional draft work programme for the Committee during 2014/15 in Appendix 2.

A concern about the ability of people to engage with new technology to support access to/provision of healthcare was raised as a possible topic for future scrutiny.

The Committee noted that from June meetings of the Committee during 2014/15 would take place at County Hall, West Bridgford.

RESOLVED to add the following items into the work programme 2014/15:

(1) progress in development of 24 hour services;

(2) the outcomes of the evaluation of the Challenge Fund to Improve Access to Primary Care pilot.

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Nottinghamshire County Council

Report to Joint City and County Health Scrutiny Committee

10 June 2014

Agenda Item: 6

REPORT OF THE CHAIRMAN OF JOINT CITY AND COUNTY HEALTH SCRUTINY COMMITTEE

INTOXICATED PATIENTS REVIEW – FINAL REPORT

Purpose of the Report

1. To allow Members the opportunity to consider evidence gathered by the study group examining the impact of intoxicated patients on the Emergency Department of Nottingham University Hospitals (NUH), as well as ratifying the study group's recommendations.

Information and Advice

2. The Joint Health Committee previously initiated a review due to long-standing concerns about the impact on patient and staff safety of alcohol intoxicated patients attending the Emergency Department at NUH.

3. The study group engaged in two evidence gathering sessions with representatives from NUH, the first with Mr Alan Davis, the High Volume Service User (HVSU) nurse responsible for reducing prolific attendance at the Emergency Department, and the second with Demas Esberger, the Clinical Director for Acute Medicine.

4. The study group heard that High Volume Service Users have always been present and have wide and varied complex needs. While they may be seen as the 'likable rogue' or the ever present constant, they do represent a significant financial burden in the current economic climate. The top 50 most prolific regular attendees presented 1628 times – which represents 1% of all presentations and in response to this the HVSU nurse specialist role was set up in 2013. The purpose of the role is to reduce inappropriate attendances at the Emergency Department and inappropriate admissions to NUH; as well as improving the social health and wellbeing of the named patients concerned - while ensuring consistency in the management of named patients and acting as a point of contact for all services.

5. The objectives are prompt identification of HVSU patients, multi-agency approach to patient care, development of patient centred care plans and the dissemination of information to all involved agencies. The cohort of top 50 attenders in 2012 was 60% male and 40% female – with the median age as 40. The largest number of presenting complaints within this cohort was 'alcohol' at 44% with 'cardiac' second at 14%. Only 8% of presenting complaints were factitious.

6. The methodology that has been followed with a view to reducing attendance and admission is primarily the addition of an HSVU alert to the patients and the development and

dissemination of a care plan; as well as, the use of speciality consultants when needed.Further to the creation of the HVSU post the number of presentations reduced from 940 to 614 in 2013 (down by 326 or 35%) with admissions down from 274 to 174 (100 or 36%). The reductions were achieved via robust care plans that all staff have access to as well as the active involvement of external agencies. Strict criteria have been put in place to guide admissions and senior clinicians have been involved with the development of care plans and the HSVU nurse has been involved in liaison with all parties.

7. The study group heard that patients in active withdrawal are admitted to NUH, which is particularly necessary since quitting alcohol 'cold turkey' can kill you – which is not the case with other drugs e.g. heroin. Patients who are dependent drinkers receive medication if they are inpatients to manage their withdrawal. Members were particularly interested to hear Mr Davis' view that people who attend the Emergency Department instead of going to the GP were equally as problematic as those who abuse alcohol.

8. The Emergency Department can become a social crutch and staff are trained not to divulge personal details to high volume service users. Only the problematic alcohol user can refer themself for treatment – the options are controlled drinking or abstinence. Alcoholics Anonymous is not for everyone due to the religious content of its anti-drinking programme.

9. The funding for the High Volume Service User nurse role came to an end on 28th April 2014. The post was funded by commissioners and no additional pot of money to fund this post had been identified. However, the post has been a win for commissioners and the hospital; patients are getting a pathway to care, and there is a financial benefit to the commissioners. The tariff per patient is £50-140 depending on complexity. Admission into a medical bed cost up to £1000, and so the Trust would rather not admit people unless absolutely necessary. **UPDATE – 22 May 2014: During the final drafting of this report, Members were informed that the HVSU nurse post had received funding for an additional year.**

10. Patients with a primary diagnosis of alcohol misuse arrive 24 hours a day, seven days a week (i.e. it is not something that occurs just on a Friday and Saturday night. While the vast majority are not violent, it is possible that the Trust underestimates the effect on other patients. While abusive people are dealt with be security, problems can arise when people suddenly become verbally abusive. At one time, a police officer was based at the hospital at potentially likely times e.g. overnight or at New Year's Eve.

11. Sometimes, people who are intoxicated are transported to hospital by ambulance. This usually only happens if they have collapsed in the street. NUH does admit to a short stay unit next to the Emergency Department, and as soon as it is safe to discharge, let them go. Intoxicated patients cannot be excluded from the four hour target in the Emergency Department.

12. Some very intoxicated patients are effectively comatose and this means that Emergency Department staff have to go through their belongings in an attempt to make an identification. Staff undergo specific mandatory training on adult safeguarding, as well as looking after themselves and defusing issues. Staff do get physically injured, although this is unusual – about two assaults per month. This means that there are a greater number of incidents caused by patients who are only ill. The delirious can be very violent. Also people who have just had a fit. Those with a meningitis infection can also be very aggressive.

13. Alcohol is a huge problem for healthcare but NUH does not have a robust means of counting alcohol intoxicated patients in terms of category. A button could be added to the system that allowed recording of the information that someone is intoxicated. This is already done with elderly patients who have fallen more than once. The problem lies in getting people to press the button. At present, NUH's figures on intoxicated patients were insufficiently robust to be useful.

14. The study group commended the valuable work undertaken by Mr Davis in his role as High Volume Service User Nurse, and rejected his suggestion that the reduction of HVSU presentations could be said to be down to good luck. Members judged that the results were more likely to be due to Mr Davis' personal effectiveness and passion for the role.

RECOMMENDATIONS

That the Joint City and County Health Scrutiny Committee recommends the following to Nottingham University Hospitals:-

1) Funds should be identified to allow the High Volume Service User Nurse role to be continued permanently within NUH

2) Robust Information on alcohol abuse and intoxication as a contributing factor in Emergency Department attendance should be captured

3) The views of patients on how the behaviour of intoxicated patients has impacted upon them should be captured and used to inform the development of Emergency Department Services

Councillor Parry Tsimbirdis
Chairman of Joint City and County Health Scrutiny Committee

For any enquiries about this report please contact: Martin Gately – 0115 9772826

Background Papers

Nil

Electoral Division(s) and Member(s) Affected

All

Nottinghamshire County Council

Report to Joint City and County Health Scrutiny Committee

10 June 2014

Agenda Item: 7

REPORT OF THE CHIEF EXECUTIVE

TERMS OF REFERENCE AND JOINT PROTOCOL

Purpose of the Report

1. To note the Committee's terms of reference and Joint Protocol (protocol attached as Appendix 1).

Information and Advice

2. County Council on 15 May 2014 agreed the following terms of reference for the Joint City and County Health Scrutiny Committee:-

JOINT CITY AND COUNTY HEALTH SCRUTINY COMMITTEE– TERMS OF REFERENCE

3. The exercise of the powers and functions set out below are delegated by the Full Council to the Joint City and County Health Scrutiny Committee:-

   3.1 To scrutinise health matters which impact both on the areas covered by Nottingham City Council and Nottinghamshire County Council.

Other Options Considered

4. None.

Reason/s for Recommendation/s

5. To inform the committee of its terms of reference.

Statutory and Policy Implications

6. This report has been compiled after consideration of implications in respect of finance, equal opportunities, human resources, crime and disorder, human rights, the safeguarding of children, sustainability and the environment and those using the service and where such implications are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

RECOMMENDATION/S

1) That the report be noted.

Mick Burrows
Chief Executive

For any enquiries about this report please contact: Martin Gately, Democratic Services Officer – 0115 977 2826

Constitutional Comments

7. As the report is for noting only, no constitutional comments are required.

Financial Comments

8. There are no financial implications arising directly from this report.

Background Papers

Except for previously published documents, which will be available elsewhere, the documents listed here will be available for inspection in accordance with Section 100D of the Local Government Act 1972.

a) Report to County Council – 15th May 2014 (published).

Electoral Division(s) and Member(s) Affected

All

PROTOCOL FOR THE OPERATION OF A JOINT COMMITTEE ON THE OVERVIEW AND SCRUTINY OF HEALTH IN GREATER NOTTINGHAM

1. Nottinghamshire County Council and Nottingham City Council established a Joint Committee between the two Authorities in 2003 to scrutinise health matters which impact upon the Greater Nottingham area.

2. The role and operation of the Joint Committee will be kept under review, with a further complete review of its responsibilities and workings to be carried out on an annual basis from the adoption of this protocol.

Role

3. The role of the Joint Committee is

    - To scrutinise health matters which impact both on the areas covered by Nottingham City Council and Nottinghamshire County Council.

4. A list of stakeholders is attached to this protocol.

Responsibilities

5. The Joint Committee will scrutinise significant health developments that cover the Greater Nottingham area. This means that a decision will impact on both Nottingham City and Nottinghamshire County residents.

6. The main focus will be on issues relating to public health with particular regard to health inequalities and access to services.

7. The agenda will be determined by the Chair and Vice-Chair, and the lead officers for both councils.

Purposes of Joint Health Scrutiny

8. Issues for potential scrutiny include:

    - Major capital projects;
    - Proposals to close services such as hospital wards and GP surgeries;
    - Issues that impact on health inequalities;
    - Issues that affect access to services such as the ending of a service or its relocation to an alternative site, including the availability of appropriate public transport;
    - Performance issues – but only those not already monitored by other bodies;
    - Issues that impact widely on public health;

- Issues that impact significantly on the local economy.

Definition of Significant Variation/Development of Health Services

9. There is no national definition. Local authorities are requested to arrive at a local definition following consultation with bodies such as Healthwatch.

10. National guidance states that in considering whether a proposal is substantial, health service organisations, committees and stakeholders should consider generally the impact of the change upon patients, carers and the public who use or have the potential to use a service. More specifically they should take into account:

    - Changes in accessibility of services, for example both reductions and increases on a particular site or changes in opening times for a particular clinic. Communities attach considerable importance to the local provision of services, and local accessibility can be a key factor in improving population health, especially for disadvantaged and minority groups. At the same time, development in medical practice and in the effective organisation of health care services may call for reorganisation including relocation of services. Thus there should be discussion of any proposal which involves the withdrawal of in-patient, day patient or diagnostic facilities for one or more speciality from the same location.

    - Impact of proposal on the wider community, and other services including economic impact, transport, regeneration;

    - Patients affected, changes may affect the whole population (such as changes to accident and emergency), or a small group (patients accessing a specialised service). If change affects a small group it may still be regarded as substantial, particularly if patients need to continue accessing that service for many years (for example renal services). There should be an informed discussion about whether this is the case and which level of impact is considered substantial;

    - Methods of service delivery, altering the way a service is delivered may be a substantial change – for example moving a particular service into community settings rather than being entirely hospital-based. The views of patients and patient's forums will be essential in such cases.

Notification of Potential Scrutiny Items

11. In line with the Guidance on Overview and Scrutiny of Health, health bodies will need to notify the lead officer of the Joint Committee secretariat of relevant issues for potential scrutiny. Commissioners and providers should agree on potential joint health scrutiny items to notify to

the joint Committee, and they should also become a standing item on executive level management meetings. Similarly Healthwatch will need to inform the secretariat of any issues they wish to raise. The secretariat will inform the Chair and Vice-Chair of issues raised so that they can decide on the best way of responding.

Chair and Vice Chair

12. The Chair and Vice Chair from each Social Services authority will be appointed in alternate years from each council. The Vice Chair will always be appointed from the authority not holding the Chair.

Size of Committee

13. It is proposed that the Joint Committee will comprise 8 non-executive members of the City Council and 8 members of the County Council. The County Council should look to include members who represent electoral divisions in Broxtowe, Gedling, Hucknall and Rushcliffe areas.

14. Allocation of seats will be determined by the two Social Services authorities involved.

Co-opted Members

15. The power of health scrutiny lies with local authorities with responsibility for Social Services i.e. the City Council and County Council for Nottinghamshire. However non-executive district council members can be co-opted to Health Scrutiny Committees on an indefinite basis or for a time-limited period. Similarly Health Scrutiny Committees have the power to co-opt other people, regardless of background, as long as it is felt that they add value to the Committee. The Joint Committee can determine any co-options.

Frequency of Meetings

16. The Joint Committee will meet as and when required with a minimum of two meetings per year.

Organisation and Conduct of Meetings

17. Notice of meetings, circulation of papers, conduct of business at meetings and voting arrangements will follow the Standing Orders of the authority which holds the Chair, or such Standing Orders which may be approved by the parent authorities. Meetings will be open to members of the public.

Officer Support

18. The secretariat for the Joint Committee will alternate annually between the two authorities with the Chair. The costs of operating the Joint Committee will be met by the Council providing the secretariat services.

Reports from the Joint Committee

19. When the Joint Committee has completed a scrutiny review, it should produce one report on behalf of the committee. The report should reflect the views of both the City Council and County Council and so the aim should be for consensus whenever possible.

20. The health service organisation(s) receiving the report must respond in writing to any requests for responses to the report or recommendations, within 28 days of receipt of the request.

Joint Health Scrutiny Protocol

Adopted	May 2005
Reviewed	July 2006
	June 2007
	April 2008
	May 2010
	June 2011
	May 2012
Amended	July 2006
	April 2008
	May 2010
	May 2014

KEY STAKEHOLDERS IN GREATER NOTTINGHAM

Nottinghamshire Social Services Authorities (who comprise the Joint Health Committee)

Nottingham City Council (eight Members)
Nottinghamshire County Council (eight Members)

District Councils

Ashfield District Council (Hucknall area)
Broxtowe Borough Council
Gedling Borough Council
Rushcliffe Borough Council

NHS Trusts

Nottingham University Hospitals NHS Trust
East Midlands Ambulance NHS Trust
Nottinghamshire Healthcare NHS Trust

Clinical Commissioning Groups

Nottingham City Clinical Commissioning Group
Nottingham West Clinical Commissioning Group
Nottingham North and East Clinical Commissioning Group
Rushcliffe Clinical Commissioning Group

NHS England Local Area Team

Health and Wellbeing Boards

Nottingham Health and Wellbeing Board
Nottinghamshire Health and Wellbeing Board

Healthwatch

Healthwatch Nottingham
Healthwatch Nottinghamshire

Nottinghamshire County Council

Report to Joint City and County Health Scrutiny Committee

10 June 2014

Agenda Item: 8

REPORT OF THE CHAIRMAN OF JOINT CITY AND COUNTY HEALTH SCRUTINY COMMITTEE

WORK PROGRAMME

Purpose of the Report

1. To introduce the Joint City and County Health Scrutiny Committee work programme.

Information and Advice

2. The Joint City and County Health Scrutiny Committee is responsible for scrutinising decisions made by NHS organisations, and reviewing other issues which impact on services provided by trusts which are accessed by both City and County residents.

3. The draft work programme for 2014-15 is attached as an appendix for information.

RECOMMENDATION

1) That the Joint City and County Health Scrutiny Committee note the content of the draft work programme for 2014-15.

Councillor Parry Tsimbiridis
Chairman of Joint City and County Health Scrutiny Committee

For any enquiries about this report please contact: Martin Gately – 0115 9772826

Background Papers

Nil

Electoral Division(s) and Member(s) Affected

All

Nottinghamshire County Council

Report to Joint City and County Health Scrutiny Committee

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